



Magazine of Ambulatory and Primary Care



June 2003

A Publication of the Primary and Ambulatory Care Strategic Healthcare Group

Message from the Office of Primary and Ambulatory Care

By W. Mark Stanton, MD, MHS, Chief Consultant,
*Primary and Ambulatory Care Strategic Healthcare Group,
located at VA Central Office, Washington, DC*

Hello from the Primary/Ambulatory Care Office in headquarters. These are certainly busy times. I want to tell you about what's been happening and share with you some plans for the future.

In collaboration with EES-Northport, we convened the Primary Care Consultant Workshop in Tampa (April 1-3, 2003). Based on the evaluations submitted by the participants the program was informative and well received. We now have 20+ Primary Care Consultants ready and willing to assist the VHA clinic staffs. The participants represented VISN and facility staff in several disciplines. (See the article that appears later in this newsletter describing the Workshop).

The program focused on: Advanced Clinic Access, Clinic Practice Management and Evaluation, Principles of Primary Care and the Consultation Process. The VISN or facility recognized the value of the training since the participants were funded by local support.

In the last MAP Newsletter I mentioned plans to conduct an Ambulatory Care Integrated Conference (another EES collaborative effort) that was tentatively scheduled for June '03, here in the Metropolitan Washington DC area. I am pleased to tell you that we have received approval from Dr. Roswell and Under Secretary Mackay for an exception to

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the 100+ rule. We anticipate a maximum of 250 participants. The conference will be held in the Doubletree Hotel, Crystal City, VA. Dr. Rivkah Lindenfeld, EES Northport, announced this conference in May 2003. The CMO's were asked to identify participants to represent the VISN and/or facility. Dr. Perlin will deliver the keynote speech. Dr. Kussman will kick-off the Cardiac Campaign. There will be concurrent sessions on Discipline Specific Interface between Primary Care and Specialty Care. Other concurrent sessions will address: Patient Health Education, Primary Care Panel Size, Telephone Access and Replacement Scheduling Application (RSA) Support of Advanced Clinic Access.

Poster sessions will include a display of information for both patients and providers on Cardiac Care. Participants will be asked to comment and rate each draft document. These comments and suggestions will be considered as the final documents are revised. In addition there will be a poster presentation on SARS-things to know before the next flu season. There will also be a poster session on: Preservation Amputation Care and Treatment (PACT How Did We Get Here, Where Are We, and Where Do We Go From Here? There will be other poster presentations.

Ms. Parlier will address Advanced Clinic Access and Dr. Reagan will discuss Clinic Process Management. Dr. Paul Heineken will do a presentation on Group Clinics. Dr. Adam Darkins will discuss Care Coordination-a proposed new Strategic Health Care Office.

There has been some discussion about a pending re-organization in the Patient Care Services Office. Perhaps by the time we meet at the June Conference, the proposed changes will be approved. I hope you can join us, meet face-to face with peers and colleagues and learn what is happening and what is anticipated for the future.

Primary Care Conference Calls are scheduled for the third Wednesday of each Month @ 1 p.m., Eastern Time. 1-800-767-1750; Access Code 28097. *ACA CALLS.

July 16	October 15
August 20	*November 19
*September 17	December 17

I want to take this opportunity to thank you for your commitment and continuing efforts to deliver quality care to our veteran patients regardless of the setting where they receive their care.

Primary Care Consultant Workshop

By Mildred Eichinger, RN, MPH

Clinical Program Manager, Office of Primary and Ambulatory Care

In collaboration with EES-Northport, a Primary Care Consultant Workshop was held April 1-3, 2003 in Tampa, Florida. Since there were no centralized funds available for participant travel the field supported participants to attend the Workshop.

The intent of the program was to improve skills in three areas:

1. Enhance the skill and knowledge of Primary Care Consultants and other participants in Clinic Process Management and Evaluation
2. Provide participants knowledge and application of Advanced Clinic Access
3. Enhance consultation skills of all participants

Understanding and applying the various principles in the Primary Care setting can help to free up staff time and appointment slots so that waiting times can be reduced. Patients and staff are usually pleased with the results. Alternative options such as group clinics can and do facilitate communication while maximizing the staff's productivity.

Faculty included Primary Care leaders such as Dr. Elwood Headley, VISN 8 Director, and other experienced primary care leaders who have served as Primary Care Consultants in the past. Ms. Renee Parlier, Clinical Program Director, Advanced Clinic Access discussed the benefits of ACA.

The Practice Management Guide developed with significant field input was distributed to all participants. The Practice Management Guide is available on the primary care website: <http://vaww.va.gov/primary>. The knowledge and skills learned at this workshop will allow us to continue and expand the Primary Care Consultation Group. We have encouraged the CMO's to select participants from the group of new Consultants to attend the AC Conference.

The closing session was led by Dr. Headley who presented a case scenario that was critiqued by three separate groups: (1) Experienced Primary Care Consultants; (2) Newly trained Primary Care Consultants; and, (3) the observing "audience." The discussion was lively, informative and fun, Thank you Dr. Headley!

An electronic distribution list has been established for this group. Some management books will be sent to each of the participants. The consultants are encouraged to attend the Ambulatory Care Conference scheduled for June 24-26, 2003 in Washington D.C..

These consultants are prepared to assist their local facility and/or make site visits to other settings in order to assess, evaluate and recommend some suggested changes to the process and flow of patients. For further information on how you can request that a Primary Care Consultant team visit your site, contact Dr. Rivkah Lindenfeld, Northport, NY. She is available through Outlook.

Advanced Clinic Access: The “Missing Link” to Better Primary Care

Interview with John Sanderson, MD, Primary Care Medical Director, VA Western New York Healthcare System conducted by Jane Roessner, PhD, Writer, Institute for Healthcare Improvement

When John Sanderson, Primary Care Medical Director for the VA Western New York Healthcare System, attended the Institute for Healthcare Improvement’s Advanced Clinic Access (ACA) meetings in 1999, he and his team at the Buffalo Primary Care Groups were already familiar with making major changes to improve the delivery of care. In the early 90s, when the primary care movement came along nationally, Buffalo replaced the old system (“not a lot of emphasis on patient needs; not a lot of emphasis on continuity over time; and not a lot of emphasis on coordinating the whole package of services we could deliver.”) with functionally integrated care teams composed of physicians, nurses, and an array of additional services like pharmacy, dietary, social work, and psychology. “We used the birth of primary care to do a lot of good things many of us had always wanted to do,” Sanderson says.

Yet the Primary Care movement in and of itself stopped short in some ways. For example, waiting times for appointments were often long and the promise of continuity was difficult to keep if patients couldn’t get in to see their own physician when they needed to be seen. As he sat and listened to the explanation of Advanced Clinic Access, Sanderson soon recognized ACA as an avenue to even better primary care. “For me, it was the missing link,” Sanderson says. “We saw right away that it could only mean better things for the quality of services and what we can do for patients. If we

could see them when they need to be seen, by the person who knows them best, in the most proper venue within our system, this would be a definite improvement.” For the Buffalo team, Advanced Clinic Access wasn’t just a matter of reducing waiting times; it was a way to further enhance care delivery. “Doing it for the patients was and still is the over-riding reason and major hook for most of my provider staff,” Sanderson explains. The results of the work they undertook following their first introduction to ACA shows the strong link between improved access and greater continuity of care. In 1999 only 10% of patients who were triaged as needing an urgent care visit actually saw their own provider, while by 2002 that percent had increased to 80% (Figure 1). During the same time period, the time to next available appointment as reported on the VHA’s waiting times database improved from 44.9 days in January 2000 to 21.1 days in June 2002 (Figure 2) while the number of enrolled patients per provider FTEE (Full Time Employee Equivalent) almost doubled. (See Figure 3).

Figure 1

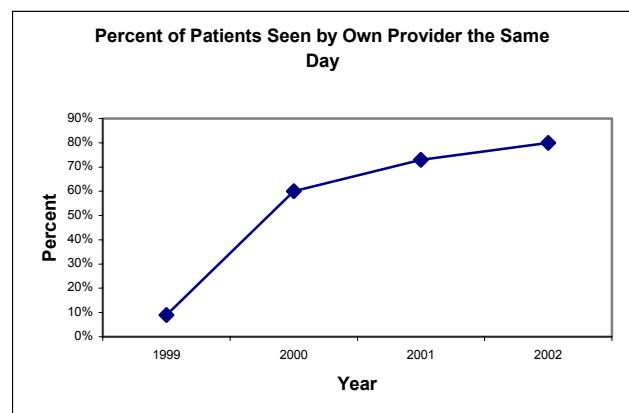
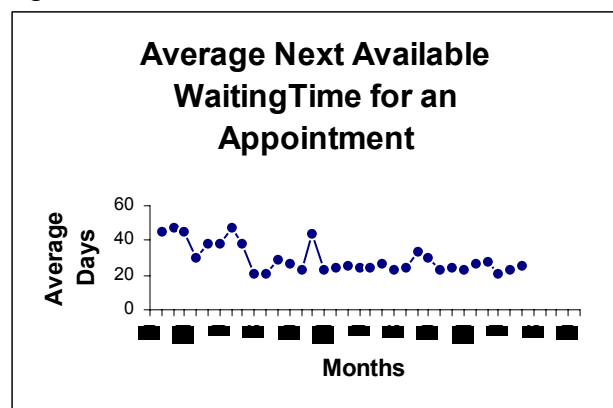


Figure 2



Getting Started

The first step for the Buffalo Primary Care Groups was to pull together a core planning and implementation team. It worked well having both the clinical and administrative Primary Care leaders participating, to drive this initiative vigorously from the staff. They were supported by a Primary Care Social Worker who was assigned to collect data a few hours per week. The project then went to the front line treatment team for input on many occasions prior to and during rollout. Each person had a decent grasp of the role expectations, and also understood how behavior changes on the part of other disciplines complemented their own. Another key was “Freeing people up not only to talk, but to act,” according to Sanderson. “Empowering them – most love the heck out of that.”

Matching Supply and Demand

The Buffalo Primary Care team undertook multiple changes at once. The first order of business was to measure supply and demand, and match the two. They knew their staffing supply, but they did not know their demand, especially for urgent, same-day care. To track demand, they measured the number of calls for same-day care, the number of patients they were able to see on the same day, and the number of patients they had to deflect to the emergency room or walk-in clinic – all on a provider-specific basis. They quickly discovered that demand for urgent care was consistently higher on certain days of the week, particularly Mondays and Fridays. They then looked at provider schedules and matched supply to demand, leaving space in their schedules for urgent care appointments based on the data they had collected.

Extending Intervals for Return Visits

Early on, the team saw that a large chunk of the demand was being created not by the patients, but by the providers’ own behavior. Providers were routinely scheduling patients for return visits in three months – because that was how it had always been done. As Sanderson explains, those three-month visits added up: “If I had 1,000 patients and saw them all four times a year, then I’d need 4,000 visits. But if I had the same number of patients and saw them twice a year, then I’d only need 2,000 visits to do the same work. So in effect, we were creating our own return demand.”

The change? Simple: schedule return visits based on a careful assessment of patient needs, instead of old habits. Sanderson admits that he had to start by changing his own behavior. “Every patient who comes in, as they’re leaving, you take five or ten seconds to make your own assessment as to what the most suitable follow up interval should be. And you base that assessment, first and foremost, on

how sick they are. Anyone who’s seriously ill should come back as often as it takes – every day or two if necessary.” Sanderson admits that he shared the VA mindset that most of his patients were old and sick and needed to be seen frequently. As time went on, however, he came to realize that a large portion of his panel was people with chronic diseases who didn’t need to be seen that often. “If people are doing accurate home monitoring of illness, such as blood sugars and blood pressures, and they’re able to recognize changes in condition and convey that information by phone or another means, we now feel very comfortable about spreading them out further into the future,” he explains, “particularly when you know they are reliable and that they will call you if something goes wrong.”

Alternative Visits

Before Advanced Clinic Access, most patients at Buffalo Primary Care ended up with a face-to-face provider visit. Today, triage nurses assess the clinical needs that arise between appointments and choose the most appropriate response. Some patients can be seen by the nurse or even treated over the phone by protocols. Nurse clinic visits are also used for such things as blood pressure checks, blood glucose checks, minor irrigation, and immunizations. Clerks and nurses can link patients directly with dietary, psychology, social work, and even pharmacy. Support staff are encouraged to contact providers for a hallway consult or telephone advice if unsure of how to handle a given situation. Some providers also hold formal telephone clinics for routine follow-up of select patients whose conditions do not require direct observation. The key here is effective internal communication – this is a prerequisite for any team seeking to respond, on any given day and at any given time, in a way that is best suited to the patient’s needs.

Adjusting to Change

These changes weren’t easy for some providers. At first, some were nervous about extending intervals for return visits. The Buffalo Primary Care Groups measured individual provider reappointment patterns, sampling reappointment behaviors every three months and sharing the results. Some of the outliers had been unable to attend educational sessions on Advanced Clinic Access; for them, the answer was more education. For others with concrete concerns, one-on-one coaching worked best. One provider, for example, wanted to be able to sit down and discuss lab results with his patients. “What you do,” Sanderson explains, “is just say, well, not only is it possible for you to do that by phone without rebooking the patient, but 90 percent of your peers down the hall do it that way and do it

very effectively.” As providers looked around and saw the success others were having extending return visit intervals, it made it easier for them to change their own behavior.

Staff satisfaction is currently quite high and staff turnover is low in Buffalo Primary Care. “The nurses like it because they feel even more invested in a given patient's care and outcome of that care,” according to Sanderson. “In the old culture, a lot of people had a lot to offer, but were shackled and unable to deliver. But this is a system where people are free to do what they're trained to do and what they really got into health care for... Compared to the old days when we weren't able to see our people when they got sick because of crammed schedules, we now have opportunities and openings built in to see patients on the day they need to be seen. Continuity is one of the precepts of primary care, and providers and patients alike benefit when it can be operationalized.”

Patients, too, had to adjust to the new system. At first, some didn't understand why they were coming back in six months instead of three. In addition to face-to-face education of patients by clerks, nurses, and everyone else on the care team, Buffalo Primary Care now includes an orientation to Advanced Clinic Access for all new patients. The message, Sanderson explains, is “This is not the old way of doing business anymore. If you're coming here, be ready for alternatives to face-to-face visits, and be ready to have reappointment intervals extended. Be ready to see other team members and not just your doctor if your need so dictates.” Handouts reinforce the message: We're changing, always trying to make care better for you. But change does entail a new experience for you. Sanderson observes that, with his own panel, the “moment of truth” for patients was the first time they called in with an urgent need and were told, yes, they could come in at 2:00 that day “Once that happened,” he says, “you had a convert.”

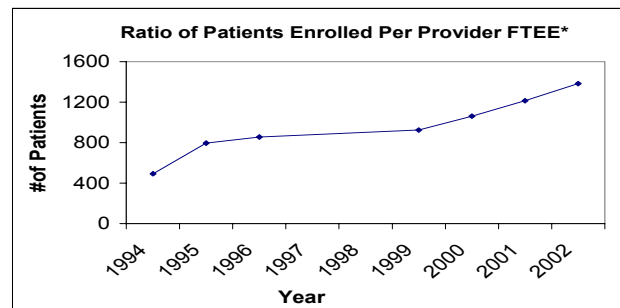
Absorbing Increased Demand

Because Buffalo Primary Care Groups carefully measure demand and supply, they know that supply has not increased, in proportion to the increase in demand. Over the past seven years, Buffalo has grown from 2,500 to about 9,000 patients in each of its Primary Care Groups. During that same time, Sanderson points out, the Primary Care system went from 20-minute to 30-minute appointments. “This was tantamount to taking a one-time 33% hit on slot availability across the board.”

Advanced Clinic Access has made it possible to absorb the hit on supply as well as meet new

demand. “The access we've created, and the internal efficiencies that resulted from our many changes have helped us swallow up a lot of this new demand,” Sanderson says. And the numbers back that assertion up. “Our waiting time over the last few years has gone down instead of up, while our total enrollment has really been climbing out of proportion to provider staffing.” Figure 3 shows the number of enrolled patients per provider FTEE (Full Time Employee Equivalent) increased from just over 400 patients in 1994 to over 1200 patients in 2002.

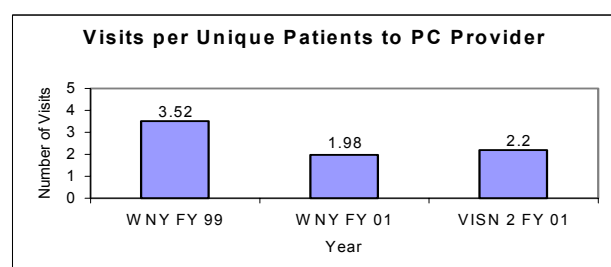
Figure 3



* FTEE = Full Time Employee Equivalent

Another indication of the increase in capacity that Buffalo achieved through Advanced Clinic Access is the decrease in the number of visits per unique patient. In 1999, just before implementing the Advanced Access changes, the number of visits per unique patient to a Buffalo primary care provider, for either elective or urgent care, was 3.52. By fiscal year 2001, that number had fallen to 1.98 (Figure 4). “That's a graphic display of the fruits of our behavior change,” Sanderson says. “We were able to cut down the number of visits per each unique by 1.5 a year. Multiply that by 30,000 unique Primary Care patients in the Western New York Healthcare System, and that's 45,000 visits averted per year. And across the network, there are close to 100,000 active Primary Care patients. You do the math – that's close to 150,000 appointment slots saved for other purposes, compared to 3 years ago.”

Figure 4



Panel Management

The decrease in the number of visits per unique patients not only reflects the ability of the system to absorb new demand, but also in large part explains how this has happened without primary care providers taking on considerably more work. With ACA the system's ability to absorb new patients doesn't translate into longer hours for primary care providers. Instead it means that primary care providers can see more patients over time by working more efficiently and by engaging the people around them in more of the care. As Sanderson says, "If it weren't for ACA we'd still be struggling to take care of smaller numbers of patients."

Primary care providers know that they are responsible for their panel of patients and that the size of this panel has been established for the VISN. Seeing one's own patients is a key component to providing quality care and is also a key to patient satisfaction. If patients can't see their own providers, they are more likely to be reappointed within the system for the same problem. Here are the elements of Buffalo's panel management approach:

- Panels are capped at 1200 active patients for MDs & 1000 for NPs
- Providers are taught the key access principles and coached on practical applications
- Adequate support staff are trained in complementary behaviors to enable effective team and alternative visit strategies
- Providers have liberty to be fully flexible and creative as long as they are successful in their care delivery

For their empanelled patients, providers are in turn expected to:

- Do same day urgent care as needed
- Plan for timely care of all patients affected by leave actions
- Take care of as many needs as possible at each visit
- Refer responsibly and by guidelines
- Maintain care quality and maximize outcomes

Extending Advanced Clinic Access to Specialty Care

Sanderson's team quickly recognized that, in order for patients to reap the full benefits of Advanced Clinic Access, it would be best to extend this approach to the entire organization. "You shouldn't just do Advanced Clinic Access in an isolated section of your building," Sanderson says. "You really should have others, particularly your specialty partners and collaborators, understand

what you're doing so that they can make synergistic changes." Accordingly, Buffalo Primary Care has coached specialty clinics on many of the specific actions that helped Primary Care to reduce demand and decrease waits. This has also helped reinforce a uniform message and behavior expectations to patients and staff alike.

Specialty clinics have a unique opportunity to do a one-time access enhancing behavior that is unavailable to Primary Care: going through their list of enrolled clinic patients one at a time, and discharging those (preferable using criteria) who no longer need to be seen by a specialist. In one VISN 2 clinic, this one-time action eliminated 40 percent of patients, creating a commensurate amount of access in one fell swoop. Sanderson notes that this idea harks back to one of the early IHI meetings "when that little light bulb went on for me that there was a better way. I see a lot of the same light bulbs going on now in others when they see the power of these ideas in action."

Primary Care has also worked with some specialty clinics to develop partnership / service agreements to better coordinate care. First, the sides agreed on referral guidelines to clarify who would be caring for patients with certain problems. Second, primary care providers were assured (and have seen it work in practice) that even though they may now take care of patients who in the past may have had more of their care delivered within the specialty domain, they know that those patients who do need a referral will be seen in a more timely way. Third, they developed new lines of communication between primary care providers and specialists. "We now have an agreement where we can pick up the phone (we gave out the phone numbers for many key specialists to all Primary Care providers at our facilities and CBOCs in Western New York) and call if we're not sure – whether a given patient needs a formal consult. We often now get clinical answers for our patients before they leave our office. This kind of an informal curbside consult provides better customer service, added support to the primary care providers, and preserves access in specialty clinics (one estimate is that up to 20% of formal consults can be handled this way)."

Spreading the Word about ACA

When Sanderson speaks to other providers in his network to spread the Advanced Clinic Access initiative, he keeps stressing its patient care benefits. "It's still the strongest hook," he says, "because this is why most people entered into medicine." Other pertinent discussion points for him are that ACA allows for:

- Better teamwork and charging of work to the proper level
- Greater flexibility in panel management over time
- Experimenting with new approaches to care delivery
- More efficient use of scarce resources

Today, Sanderson himself is a changed provider. “It’s funny,” he says. “I’m spreading appointments out more, but I feel even more connected to a lot of these guys because they’re in seeing others on the team and we’re on the phone maybe a little more, and I know deep down that we can deliver for them when their need arises. I have trouble remembering the old days. We are now better than ever for our patients, and it’s much more fun too.”

San Juan VAMC Transforms

“Waits and Delays” into “Open Access/Best Practice”

Myriam Zayas, Medical Administrative Officer, San Juan VA Medical Center

When veterans in San Juan requested ophthalmology appointments last August, they were told they had to wait over six months. This experience was one example of the lack of availability that seriously affected the public image of Puerto Rico’s Veterans Affairs Medical Center. However, SJVAMC’s Ambulatory Care Service staff tackled the problem with determination. The result was the conversion of their Ambulatory Care clinics into open access practices in less than a year.

The San Juan VA Medical Center serves a population of approximately 63,000 unique veterans and like most modern care facilities it is oriented towards Ambulatory Care. Besides the main facilities located in the capital of this Caribbean Island, there are two Satellite Clinics, and three CBOCs (including two on the Virgin Islands).

Two main goals were involved in the conversion to open access. The first was to transform our Primary Care program to the open access model and to enroll and serve new veterans within 30 days. The strategies and methods used to transform the Primary Care program at the main facility and community based clinics into open access facilities included a review of patient flow and re-routing to follow an organized and efficient pattern. New veterans are now able to complete Registration and Enrollment at the “fast track/emergency room area” where specially trained clerks and nursing staff expedite the process. After the patient is registered, a physician performs a general physical examination. A consult is generated and sent to

Primary Care after this exam for an initial appointment.

Upon receipt of the consult from the Fast Track clinic, the Primary Care Coordinator assigns the veteran to a Primary Care provider and panel, schedules an initial appointment, and informs the veteran by phone or letter. This process is not to take longer than 30 days. A few strategies have been implemented to keep waiting times low. For example, a written leave policy and a re-scheduling policy are used to keep continuity in staffing and rescheduling actions. Also, a contingency plan for emergencies and exceptions is in place in the Primary Care program, as well as in the specialty clinics. This includes provisions for urgent care if the patient needs to be seen before the initial Primary Care appointment.

The second goal was to apply the open access model to a number of specific subspecialties, such as cardiology, urology, audiology and ophthalmology. A number of the same guidelines were created and followed in order to insure continuity and to make care available within a reasonable timeframe.

One additional component, which made this transition a success, was the implementation of a case management program for consultations. The purpose of this program was to:

- Reduce demand and maintain the gains through the review of all consultations generated by Primary Care Providers using pre-established criteria.
- Reduce backlog by performing special reviews for cases waiting for evaluation and providing necessary data to establish priorities for care.

Another goal of the program was improvement in patient satisfaction and the coordination of care by providing individual managed care to special cases identified by any health care provider. Identification of these cases was made according to criteria developed by the Ambulatory Care Service. Currently, five nurses screen all consults from Primary Care to all specialty care. Staff members insure that consults meet all criteria for referral and are complete in regard to documentation and supporting items such as lab results.

The San Juan, VA Medical Center Primary Care Program has four (4) primary care teams. Each team has the following composition: 4 or 5 physicians, 2 NP’s, 4-6 RN’s, 1 nutritionist, 1 SW, 3 PSA’s, and 1 pharmacist.

TEAMS	PHYSICIANS	NURSE PRACTITIONERS	NURSES	NUTRITIONISTS	SOCIAL WORKERS	PSAs	PHARMA- CISTS	TOTALS
4	19	8	22	4	4	12	4	73
1. ADMINISTRATIVE EMPLOYEES SUPERVISOR				1				
2. NURSE SUPERVISOR* (LOCATED AT TEAM B)				1				
3. PODIATRIST* FOR ALL PCC (LOCATED AT TEAM C)				1				
4. CASE MANAGERS				4				
5. ADPAC				1				
6. Telephone Care Program				6				
TOTAL OTHER PERSONNEL:				14				

The following actions were taken to improve the waiting times in the performance measures clinics and get open access in some of them:

1. **Established Contingency plan:** Written Annual/Sick Leave Policy and Cancellations/Re-Scheduling Policy.
2. **Strategies to improve access:**
 - Physicians have 17 slots for schedule patients (20 minutes each).
 - Four slots are kept for unscheduled patients: 10:40 a.m., 11:40 a.m., 2:40 p.m. and 3:00 p.m.
 - Established open appointment policy.
 - Promoted the use of the Telephone Clinics to inform patients about lab results.
 - Every unscheduled patient is seen.
 - Strict monitor of physician's disposition of patients.
 - Set up of the clinics was established at 112 days.
 - Standardization of the Primary Care Program.
 - Established PCMM Enrollment Coordinator position.
 - Patient flow is standardized in every team.
3. **Strategies to increase capacity:**
 - Physicians and Nurse Practitioners panels were established at 1,200 patients each.
 - Physicians and Nurses are full time in Primary Care.
 - Preventive Medicine functions were divided between the physicians and nurses.
4. **Strategies to reduce backlog:** Do today's work today.
5. **Strategies to improve clinic flow:**

- Written agreements between the Primary Care program and the sub-specialty clinics.
- Established the Case managers program.
- Every primary care consult is reviewed for appropriateness and continuous stay criteria.
- Special clinics are conducted to reduce backlog.
- Clinical reminders were established.
- Peer reviews are conducted on a monthly basis.

6. **Outcomes:**

- Primary care is in open access.
- Performance Measures Waiting Time in Clinics of: Audiology, Cardiology, Ophthalmology, Orthopedics and Urology are in less than 30 days.
- Working now for agreements with Gastroenterology, Rheumatology, Dermatology and other specialty clinics to reduce the next available appointment to less than 30 days.

We also have the following monitors in place:

- PCMM Panels monthly purge
- Patient disposition monitor
- Drug and X rays utilization monitor
- Provider/team-specific data on % of consultations meeting criteria.
- Provider/team-specific data on % of cases meeting continuous stay/care criteria.
- Provider-specific data on compliance with preventive medicine and clinical guidelines

- Provider/team-specific data on patient satisfaction.
- No show rates and number of unscheduled patients
- Provider productivity reports
- Slot utilization
- Open appointments spot checks are conducted
- Telephone appointment usage

These monitors have allowed us to increase productivity by providing the information for adjustments on an ongoing basis. For example, if telephone appointments are not being used, the patient will need to visit us more often. Monitoring permits us to correct situations as they occur.

The outcome of implementing all of these strategies and disciplines is that we now enjoy open access in primary care.

Perseverance, planning and hard work played a key role in this achievement, which we are very proud of at the SJVAMC. Come visit us soon!

Cardiology Acute Myocardial Infarction (AMI) Action Plan Campaign

The VA sponsored study by Harvard Medical School and Price Waterhouse Cooper provided a comparative analysis of VA and Medicare heart attack patients during a two-year period: 1997-1999. The analysis indicated that veterans have a higher mortality at 30 days, one, two, and three years post MI due to two critical factors: veterans travel twice as far for VA critical cardiac care, and are less likely to receive invasive cardiac procedures than Medicare patients.

Based on these results, the VHA and Patient Care Services will “kick-off” a AMI Cardiology Campaign Plan, aimed to improve VA’s cardiac care and delivery of services, June 24-26, 2003 at the VA’s Integrated Ambulatory Care Conference at the Double Tree Hotel in Crystal City. The Campaign Plan consists of major initiatives and reflects VA’s commitment to provide optimal cardiology diagnosis and treatment capabilities.

Initiatives include:

- Development and distribution of effective patient and provider educational materials *Time is Life for Heart Attacks* which showcase three themes: (1) Know signs and symptoms of a heart attack, (2) call 9-1-1 and (3) transport to the nearest medical facility and develop a personal action plan prior to experiencing heart attack symptoms.
- Selection of non-VHA cardiology experts from academic medical centers, to serve on a Blue Ribbon Panel Advisory Committee to the Under Secretary for Health.
- Complete a major VHA infrastructure assessment to indicate cardiac diagnostic equipment needs, cardiac catheter lab updates, staffing and referral patterns for rapid evaluation and treatment of veterans diagnosed with AMI. Staff at the facility and VISN level, will complete a self-evaluation of cardiology services while developing action plans to upgrade cardiology capability.
- Development of VA Cardiology Clinical Practice Guidelines and Practice Standards for cardiac care services throughout VHA.
- Development and dissemination of an Acute Myocardial Infarction (AMI) Directive and establishment of Performance Measures for cardiology care.
- Development of quality improvement measures, peer review of AMI cases & benchmarking with private health care sector.
- Selection of a Tiger Team to explore the potential for tele-cardiology with links to 163 VA Medical Centers for remote EKG readings, remote echo-cardiology and nuclear medicine and re-engineer cardiology service delivery across state lines.

Contact: Marianne Mathewson-Chapman, PhD, ARNP (111)

Schedule for MAP articles

FLOW	3rd Q/2003			4 th Q/2003			1 st Q/2004			2nd st Q/2004		
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March
Articles Submitted	18			18			15			21		
Distribute to Board Members		9			8			5			11	
Comments to OPAC			4		29				23			3
Final Presentation to 112			18			10			17			17
Electronic & Hard Copy Distribution			25			17			24			31


Website <http://vaww.va.gov/primary>

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**It is clearly my intent to continue with the significant contributions made through the newsletter.
Please feel free to contact me electronically if you have any ideas or recommendations for future newsletters.*

Articles may be submitted electronically at any time to Mildred Eichinger and/or Renee Hodges.



We welcome your articles related to any current Issues in the area of healthcare in general or specifically in the field of ambulatory and primary care. Contact Mildred Eichinger at 202-273-8552 or Renee Hodges at 202-273-8558 if you have any questions.